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## **Telepsychotherapy in the Age of COVID-19: A commentary**

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### **Abstract**

This is a commentary on fifteen articles addressing some of the major emergent challenges in provision of mental health services during the COVID-19 pandemic crisis, offering telepsychiatry as a viable and elegant solution to maintaining psychotherapy within and post-pandemic. The papers in the special issue both build on existing telepsychotherapy initiatives and offer rapid responses to the early phase of COVID-19. Two papers explore the relative effectiveness of in-person supervision and telesupervision, proposing telesupervision as a feasible alternative; and offering practical considerations to maintain effective clinical care in training settings whilst implementing telepsychology. Ten papers address technological challenges, with recommendations to create, enhance and optimally configure telepsychotherapy services for clients across the mental health spectrum from common mental health problems, clinical high risk for psychosis, high risk for suicide, post-traumatic stress disorder, and family intervention. Turning to process, two papers explore psychotherapists' attitudes towards online psychotherapy and their use of technology in practice. Finally, one paper addressed system considerations, describing the development of a virtual partial hospital program for acute psychiatric patients stepping down from inpatient hospitalization. We discuss the key themes emerging from this corpus of work, linking these themes to the current state of evidence regarding the mental health response to covid-19 pandemic. Crucially, the value of this special issue goes beyond the current crisis, enabling psychotherapists to be better prepared for physical distancing situations that they may face in the future.

**Keywords:** COVID-19; Coronavirus; psychotherapy; telepsychotherapy; commentary, mental health, psychiatry, clinical psychology.

Coronavirus 2019 (COVID-19), a newly emergent infectious disease caused by the novel severe acute respiratory syndrome coronavirus 2 virus (SARS-CoV-2), originated in December 2019 from mainland China (Li et al., 2020). The disease has rapidly escalated to a global pandemic, with over 3 million cases and significant mortality by the end of April 2020 (when this issue was sent to production). Due to methodological differences in testing and case recording between countries these numbers are also likely to significantly underestimate the true prevalence of COVID-19 in the population (WHO, 2020). Alongside the impact on hospital and physical health care, the fast spread of COVID-19 has placed significant strains on providing mental health services by negatively impacting the capacity, availability, responsiveness and resilience of public and private healthcare systems worldwide (Emanuel et al., 2020; Legido-Quigley et al., 2020).

There is emerging evidence of the psychological impact of COVID-19 on population (Wang et al., 2020), both directly due to the distress accompanying confirmed cases in individuals and their loved ones, and indirectly due to population health policy and interventions such as quarantine (Pancani et al., 2020). It should be emphasized that the majority of people are not expected to suffer from mental disorders emerging from the pandemic and its impact (Taylor, 2019). However, a significant percentage will experience intense emotional adjustment reactions, including fear of contagion (Zhou, 2020), impact of prolonged quarantine (Brooks et al., 2020; Xiao, 2020), the death of relatives (Wang et al., 2020), or increased social adversity as a consequence of geopolitical instability to civil society associated with the economic crisis (Silva,

Resurrección, Antunes, Frاسquilho, & Cardoso, 2018). Against a pre-existing backdrop of increasingly stretched mental health services in developed and developing countries, the direct and indirect psychosocial effects of COVID-19 present an urgent challenge for mental health research, practice and policy (Holmes et al., 2020).

In this context, increasing access to psychological therapies through technologically informed approaches (telepsychotherapy) presents an opportunity to adapt to the mental health care delivery challenges posed by COVID-19 whilst also supporting client choice around mode and flexibility of delivery. The collection of articles we comment upon highlight the potential of telepsychotherapy in the age of COVID-19. These articles offer readers a blend of reports of existing telepsychotherapy initiatives refracted through the lens of COVID-19, and reports of emergent empirical data pertaining to telepsychotherapy during the pandemic. We organize our observations on these papers through first identifying a range of core groups at risk for mental health sequelae during the COVID-19 outbreak. Second, we outline how the current collection of papers offer new perspectives on how to respond to these groups. Finally, we look ‘beyond the curve’ to discuss recommendations and evidence on how to design and deliver telepsychotherapy in accordance with the challenges and limitations these reports highlight. It is important to note that appreciations included in this special issue also allows psychotherapists to prepare to enter any physical distancing situation they may face in the future, such as areas that lack local providers, crisis situations (e.g. conflict or natural disasters) or future health pandemics.

### **Groups at risk during and after the COVID-19 pandemic**

It is possible to detect at least three major groups at risk for psychological morbidity during and after the COVID-19 pandemic (Inchausti, García-Poveda, Prado-

Abril & Sánchez-Reales, 2020). The first group are healthcare professionals, particularly those working in inpatient physical health settings, who experience higher frequency of exposure to the virus and higher viral load in the workplace; compounded by significantly increased workload, high risk procedures and the availability of necessary personal protective equipment (PPE). Evidence from the current, and previous similar, coronavirus outbreaks indicate health professionals are at risk of elevated levels of depression, anxiety and sleep disorders (Al-Rabiaah et al, 2020; Li et al, 2020).

The second elevated risk group include individuals who, as a result of the crisis, have been exposed to potentially traumatic events such as loss of a loved one, threats to one's health and to the ability to work and make a living. These people may express symptoms of posttraumatic stress disorder (PTSD), depression or complicated grief disorder, consistent with the literature on psychological and psychiatric sequelae of global emergencies or disasters (Goldmann & Galea, 2014). This group may not emerge immediately within the pandemic, and presentations may only become apparent after several months, even after the incidence of COVID-19 has peaked, as is the case with previous coronavirus outbreaks (Tsang et al., 2004). The emerging post-hospitalization syndrome in survivors of COVID-19, which includes medical and psychological sequelae, is also a problem of growing concern in global healthcare systems (Stam, Stucki, & Bickenbach, 2020).

A third group of people at increased risk for psychological problems consists of people with pre-existing diagnosed psychiatric disorders, especially those with severe or complex ones. Their existing presentation may be exacerbated by extreme isolation due to exposure to either the virus or associated physical distancing, and physical distancing may itself exacerbate previous experience of social isolation in this vulnerable group. It

is this group that the insights from the current papers are most immediately relevant to, although we highlight that lessons can also be learned in terms of therapeutic process and signposting for the other risk groups.

**Assisting frontline professionals, COVID-19 patients and their relatives,  
and people with pre-existing psychiatric disorders**

As Duan and Zhu (2020) highlight, specialized psychotherapeutic interventions for COVID-19 should be dynamic and flexible enough to adapt quickly to the different phases of the pandemic. This emphasis on adaptation and flexibility is a common thread, resonates with the recommendations made by all the authors in the special issue. As with previous crises (Mohammed et al., 2015), mental health emergency response includes in the early stages an active collaboration between clinical psychologists, psychotherapist and psychological intervention specialists with the rest of the multi-professional healthcare system in the treatment of the immediate impacts of COVID-19 presentations. This may take the shape of organizing or enabling healthcare systems to orientate towards psychological impacts of a pandemic, facilitate public mental health approaches to increasing population awareness of mental health; or organizing systems for psychologically informed interventions. This may also include task-shifting of psychological interventions either to delivery through digital means, or by different professional groups. According to these recommendations a number of potential therapeutic targets can be identified.

*Health Professionals*

Firstly, training and support for health professionals at ‘high exposure risk’ to identify and manage emotional reactions, that may hinder their clinical work in frontline health delivery. The core driver here is promoting psychological resilience for



professionals who have frontline duties during a pandemic (Chen et al., 2020). Key therapeutic targets may include managing anxiety, fear of contagion, episodes of acute stress or promoting self-care/reducing burnout. The breadth of different approaches to Telepsychotherapy and eHealth gives considerable scope to tailor potential interventions to the needs of health professionals; with Bennett et al.'s (2020) review delineating key aspects of what works for whom in eHealth. A related point is that eHealth is best placed to deliver when captured within an ethical evidence based-framework – a further theme of the papers. As an example, in acute health settings interventions such as psychological debriefing, critical incident stress debriefing or other single session intervention that *mandate* staff to talk about mental health responses are to be avoided, although compassionate and sensitive awareness of the impact of critical care on health care professionals remains a powerful and important principle.

#### *Mental health of COVID-19 patients*

Addressing psychological distress among infected individuals and their relatives requires special attention. It is important to engage emotionally vulnerable groups, especially people with previous psychopathology when these individuals are undergoing COVID-19 treatment or in quarantine. Here opportunities for psychotherapy and indeed telepsychotherapy are limited, but the mental health symptoms of this group of patients with COVID-19 should still be monitored. Given physical distancing and hospital pressures front-line psychological support either needs to be facilitated by medical staff involved in immediate care (which may not be possible if the health system is at capacity) or be implemented indirectly through telecare systems. Attention should also be given to relatives of patients admitted by the coronavirus in a severe condition, poorly prognosed, or who have already died. While addressing such individuals, it is essential not to

pathologize normal emotional reactions of the family members and it is important to establish clear and consensual criteria with all the professionals involved to determine whether or not intervention is likely to be beneficial (von Blanckenburg & Leppin, 2018). Normal reactions of grief are expected and the need for psychological support should be assessed. In this sense, Rosen & Glassman's (2020) paper provide a roadmap towards how clinicians can use telepsychotherapy technologies for providing strengths- based preventive interventions for coping with distress during periods of disruption, life-threat and loss; and for delivery of effective treatments to people who develop chronic conditions in response to traumatic stress.

*Adaptations of psychological interventions for existing mental health presentations*

Thirdly, when adapting psychotherapy delivery to a telepsychotherapy format for people with pre-existing psychiatric disorders continuity of care and continuity of therapeutic experience is highly important. In this regard, Hom et al.'s (2020) article presents encouraging preliminary data relating to a partial hospital program that serves acute psychiatric patients stepping down from inpatient hospitalization. The move to an online environment was accomplished with a high degree of acceptance from patients and staff, and the paper offers a useful account of the practicalities and pragmatics of doing so. Thinking across the spectrum of common mental health disorders, Bennett et al.'s (2020) review of reviews supports the view that outpatient psychological interventions targeting common mental health (i.e., depression, anxiety or substance abuse) can be effectively carried out by telepsychotherapy, although the authors highlight mixed evidence with regard to recommendation around guided versus unguided telepsychotherapy, effectiveness against controls, and the potential for elevated attrition

rates in telepsychotherapy. In addition, these authors point out that eHealth interventions have the potential to be an effective tool for redressing both new and old psychotherapy access barriers, particularly when engagement is boosted by use of (online) reminders and feedback. This is consistent with existing evidence that phone and internet enabled psychological interventions are clinically effective in a wide variety of mental disorders (Irvine et al., 2020). Turning to more specialised populations, DeLuca et al.'s (2020) paper highlights the need for youth at clinical high risk for psychosis to receive telepsychotherapy during the COVID-19 outbreak. These authors highlight the need to maintain engagement via online methods, but also highlight the potential for psychological distress to be exacerbated, with corresponding risks for subsequent vulnerability to psychosis and other mental health problems. We draw attention to DeLuca et al.'s mapping of target risks (e.g. stress sensitivity, suicidality) to psychiatric best practice, implications from psychotherapeutic principles (e.g. Cognitive Behavioral Therapy, CBT) and adaptation to a telepsychotherapy format. In a similar vein, there is increasing concern that the mental health impacts, and wider socioeconomic ramifications of COVID-19 may increase suicide risk across populations (Gunnell et al., 2020). In relation to individuals with high risk for suicide, Jobes & Crumlish's (2020) describe adaptation of a suicide-focused and evidence-based intervention –the Collaborative Assessment and Management of Suicidality (CAMS)– for delivery via telepsychotherapy. These authors highlight that the existing framework for CAMS offered a baseline structure for adaptation to the COVID-19 challenge, and aligns with other suicide prevention resources. This therapeutic pragmatism and pooling of resources is a further emergent theme of the mental health response to the pandemic. Finally, although the rates of infection and hospitalization for COVID-19 are thus far relatively low in children and young people there is an awareness that children are at risk both directly of mental health

sequelae (particularly in the case of children with existing health conditions) and indirectly due to social and economic impacts on families. Again, a pragmatic approach building from existing evidence base has much to offer. In reviewing their use of telepsychotherapy treatments with children with neurological conditions and their families, Wade et al. (2020) offer a strong evidence base, both in terms of effectiveness and in process-driven adaptations for delivery of telepsychotherapy to children and families. Their broad overview grounded in two decades of implementation research offers important insights into effective approaches for young people and families including online family problem-solving treatment and online parenting skills training. These authors also draw attention to the impact of differing levels of socioeconomic strata, which leads us to caution that the move to telepsychotherapy does carry risks in terms of digital disadvantage for clients and families with limited access to ‘fit-for-purpose’ technology. Similarly, Riegler et al. (2020) report that online parenting skills for military Veterans can be effective to support at-risk families; whilst also promoting positive parent-child interactions and family functioning during (and potentially beyond) the COVID-19 crisis.

### **Going beyond the curve**

The papers in the special issue largely focus on adaptations to existing approaches, based on emerging research. However, it is important to take a long view and look at the implications for mental health as the pandemic plateaus. Implicit in this view is a recognition that COVID-19 presents as an infection that is highly likely to occur in waves, with the potential for alternating periods of less and greater physical distancing. In the long term, mental health stakeholders are preparing for an increase in mental health symptoms such as hypochondriasis, anxiety, insomnia or acute stress, as well as

symptoms consistent with PTSD across health systems. The likelihood is that this work will involve eHealth to a greater extent and also include telepsychotherapy. Evidence based-psychotherapies will be crucial here (NICE 2014, 2018). An example of this is the article by Stewart et al. (2020) demonstrating pilot feasibility and effectiveness data on outcomes for trauma-focused CBT delivered via telepsychotherapy in children and adolescents aged 7 to 18 with PTSD. However the strong theme of ethical practice that emerges through the papers collected underscore that formal psychotherapy still requires careful assessment as a first step, and active monitoring throughout. Special attention should also be paid to: potential for “re-traumatization” of PTSD presentations where trauma-focused psychotherapies are implemented without adequate psychotherapeutic frameworks and structures (Duckworth & Follette, 2012); and guarding against the development of interventions for those that have recovered from COVID-19 that stigmatize or block access of the to a new functional identity as survivors of the pandemic (Muldoon et al., 2019). Evidence from West Africa of psychological stigma relating to Ebola survivor status is instructive here (Hoover et al., 2018). Individuals affected by COVID-19 also should be encouraged to retain a sense of their overall identity, rather than have identity subsumed into survivorship.

It is also important to recognize that COVID-19 has already created the conditions for societal rupture across economic, social and political levels. Therefore, the work of mental health systems going forward may well sit within a social determinants of mental health model (e.g., Lund et al., 2018). As the impact of the pandemic is expected to be manifested across different life domains, mental health professionals might need to collaborate with other professionals such as occupational counsellors to address the need to find a new job for their clients.

### **Current and emerging challenges from the pandemic**

In organizing psychological assistance within and across various stages of the pandemic, we highlight four major challenges:

First, health care systems include deficits in material and human resources carry risk of rendering them less responsive to psychological aspects of the pandemic. For instance, deficits such as lack of specialization in crisis interventions (Shultz, Baingana, & Neria, 2015; Shultz & Neria, 2013) and scarcity of human resources may lead to accumulating multiple responsibilities, which in turn reduce the effectiveness of interventions (Duan & Zhu, 2020).

Second, there exists a very real danger that the public underestimate the (short- and long-term) psychological consequences of pandemics. Although accumulating evidence exists with regard to psychological distress, it is not clear whether policy makers will emphasize mental health, particularly in low resource and conflict settings.

The third challenge relates to poor planning and coordination of psychological interventions, especially when they are applied at different levels and by different professionals (Zhang, Wu, Zhao, & Zhang, 2020). In China, at the start of the COVID-19 outbreak, the absence of adequate planning of psychological interventions led to fragmented or disorganized implementation, compromising effectiveness and efficacy, and hampering access to available health resources.

Finally, there is risk attached to early crisis responses, leading to a proliferation of interventions and frameworks associated with an oversupply of well-intentioned but potentially non-evidence based, psychological assistance, often non-governmental

organizations (NGO) and the third sector. This is not to say all NGO interventions are compromised, and indeed prevention in mental health is highly desirable. However, delivery of preventive interventions must be balanced by delivery and/or supervision applied by appropriately qualified professionals (Loewenstein, 2018; Ogden, 2019). Although general in nature, these concerns are equally applicable to both psychotherapy and telepsychotherapy. In reviewing the 28 popular English language mental health mobile apps, Wang, Fagan, & Yu (2020) noted that only five were found to have strong empirical support. In addition, few empirical studies fully evaluate negative or harmful effects of app delivery, although iatrogenic risks of mobile applications have been identified.

### **Maintaining the quality of therapeutic experience for COVID-19 telepsychotherapy**

What key considerations are there for practice and technique in adapting telepsychotherapy to the demands of a COVID-19 and post-COVID therapeutic landscape? Again, clues can be drawn from existing best practice in telepsychotherapy. As van Daele et al. (2020) recommend, design and provision of high-quality telepsychotherapy interventions require to be tailored and personalized to clients by professionals and organizations, involving the clients in the entire development and implementation process. Where health services, regulatory agencies and developers have enough flexibility, there is scope for those with existing mental health conditions should continue their psychological interventions by technology enabled means (Bennett et al., 2020; Hom et al., 2020; Jobes & Crumlish, 2020). Alongside this, psychotherapists attitudes, competence and confidence in adapting therapy are vital. As Békés & Doorn (2020) report in their cross-sectional survey of psychotherapist attitudes toward online

psychotherapy during COVID-19, there is already evidence across multiple therapeutic modalities that psychotherapists across continents have been able to adjust their own and clients' expectations of therapy to an online environment with broadly positive findings in relation to confidence. However, it is important to note that therapist fatigue and lack of confidence link to negative attitudes to telepsychotherapy, signaling the need for education, support and supervision. As we go forward, qualitative methodologies are of value in deconstructing therapist experience of COVID-19 telepsychotherapy. Indeed, MacMullin, Jerry, & Cook (2020) give us much to consider in this regard there with specific challenges emerging such as familiarity with the technology (both psychotherapist and client), adaptation of the therapeutic intervention, awareness of the additional parameters of delivering psychotherapy in lockdown conditions, potential misunderstandings and miscommunications, potential benefits and risks (e.g. limits to patient confidentiality), and the accompanying question of the purpose of psychotherapy in such unusual circumstances.

Regarding the quality of the therapeutic alliance in face-to-face psychotherapy versus telepsychotherapy, Marchand et al. (2020) reported that telepsychotherapy did not interfere with the establishment of the working alliance over the course of the treatment in patients with generalized anxiety disorder. On the contrary, these authors reported that clients showed a stronger working alliance in telepsychotherapy delivered in videoconference than in conventional psychotherapy. This alerts us to the potential for unexpected opportunities in telepsychotherapy,

Indeed, attunement to the therapeutic relationship and detection of ruptures in clients that are in the process of, or have already switched to telepsychotherapy is an important aspect of technique. For example, Consistent with principles for identifying



and repairing alliance ruptures (Safran & Muran, 2000), the therapist may first ask for feedback about the new condition: “How do you feel seeing me on video? How is it to you showing elements of your home? Do you sense I’m close as before or more distant?”. Similarly,, attention to nonverbal markers becomes even more important. On video, facial markers are relatively easy to detect, whereas attention to the non-verbal dimension requires some adjustment. The clinician may note the patient’s posture (e.g. slouching), which may be a sign of depression or lack of trust and confidence in the modality, or that they looking elsewhere. The clinician can gently note these markers and bring them to the center of the conversation. To collect more information, the clinician may ask the client to zoom out, where possible, so a larger part of the body becomes visible and signals from the upper part of the body become easier to detect.

Importantly, telepsychotherapy may well call for tele-supervision. Indeed, physical distancing makes this a necessity. Tarlow et al.,’s (2020) study uses a multiple baseline single-case design to compare the relative effectiveness of in-person supervision and telesupervision. The results obtained suggests that supervisees reported similar levels of supervision satisfaction and supervisory working alliance during in-person supervision and telesupervision. Supervisees’ emphasis of supervisor characteristics, including openness, supportiveness, and empathy, underscores the importance of the supervisory relationship regardless of supervision format. Supervisees also emphasized the importance of supervisors’ competence with supervision technology. These authors suggest that for some jurisdictions and organizations, adherence to existing supervision standards may be sufficient for the provision of telesupervision that is acceptable, effective, and ethical, though additional research comparing the effectiveness of supervision formats is recommended. Therefore, clinicians, providers and policymakers weighing the benefits of telesupervision against its potential risks must therefore balance

the directive to “do no harm” (nonmaleficence) with the goals of promoting health (beneficence) and providing equitable access to care for all (justice). Mental health care providers adopting telesupervision can also seek out and consult with colleagues who are experienced with telepsychotherapy and telesupervision during this period of transition. We suggest there is a synergy here. If psychotherapy is delivered in an online environment, there is a certain intuitive fit to also supervise or receive supervision in an online format –if supervisors model the process this may help supervisees increase familiarity with the systems and process; whilst also normalizing the experience.

Similarly, there is a need for synchrony between training, client care and research. Hames et al (2020) present findings from a survey of North American training clinic directors from the Association of Psychology Training Clinics (APTC) related to the transition to telepsychology. These authors blend short-term response with a range of recommendations going forward for clinic reopening and potential future closures as the pandemic continues. Although focused on the United States, this approach gives useful insights for training programs in other countries and regions.

In summary, based on the papers in this special issue we have reviewed we endorse the key themes of flexibility, ethical integrity, and trying where possible to integrate telepsychotherapy into existing treatment systems and paradigms. Based on our own observations we also add the following points to guide clinicians in adapting telepsychotherapy:

- Transparency in setting up and implementing therapy – this may include drafting of psychotherapeutics contracts,
- Balancing normalization with distress. During pandemic and physical distancing situations affect is heightened – transient emotional states such as fear, anger, anxiety,

obsessions, guilt, constriction, rebellion against authority, emotion and behavioral dysregulation, are to be expected (both from clients and clinicians). Normalization is vital to acknowledge the common humanity of the situation – that suffering is human and mostly unavoidable, but that ongoing, stable or severe distress should not be ignored or minimized. Common factors (e.g., Norcross & Lambert, 2019) are also important than usual. Adjustment to the ‘new normal’ is normal and patients experience is human. Where sharing and self-disclosure are appropriate, psychotherapists sharing of similar may reduce feelings of self-shaming, self-criticism stigma, or guilt for one’s own weaknesses. Whilst maintaining self-monitoring, clinicians may disclose moments in which they experienced transient, but more acute feelings of anxiety, anger etc., than one ordinarily would (Dimaggio, Ottavi, Popolo, & Salvatore, 2020). This helps create a sense of human connection and reduces in session risk, on the client’s side of self-blaming or setting unrealistic standards of good mental health for the self.

- Give consideration to the therapeutic environment. Working from home or an unusual space requires choices around background, use of non-verbal cues, and the balance of using video to create a more ‘usual’ environment, balanced against the anxieties of clients (and perhaps psychotherapists) of relating in an ‘unusual’ situation. In a similar vein, psychotherapists may need to discuss and guide clients around how the client constructs their online ‘space’ for therapy.
- Creativity. Whilst for some clients the restrictions of physical distancing may require psychotherapy to take a more immediate focus on managing distress and maintaining self-regulation, therapists may still be able to use a digital environment creatively to explore and expand the healthy self (Dimaggio et al., 2020). The profound changes involved in living with and through physical distancing may enable psychotherapists

to help clients draw links from present experience to lifelong vulnerabilities , giving new opportunities for therapeutic work such as linking behavioral avoidance to schema (Inchausti, Prado-Abril, Sánchez-Reales, Vilagrà-Ruiz, Fonseca-Pedrero, 2018) or behavioral experiments (such as where clients are in lockdown with partners of families).

We emphasize that these recommendations have relevance beyond the current crisis, and indeed may even help many psychotherapists unfamiliar with telepsychotherapy to approach this modality. The flexibility of telepsychotherapy offers opportunities to reach clients who do not have access to face-to-face psychotherapy in their locality, or struggle to engage due to professional or logistical pressures. Take the example of a client in the creative industries, who due to work relocation had switched to telepsychotherapy prior to the pandemic. After the onset of physical distancing, this client experienced a relapse in her interpersonal difficulties, alongside pandemic-exacerbated health anxiety. Physical distancing limited the scope for behavioral experiments. However, a combined experiential technique using art, mindfulness and guided discovery was possible via telepsychotherapy (Dimaggio et al., 2020). Coupled with therapeutic roleplay this enabled the client to connect with her negative affect and cognitions, whilst also noting an improvement in her creativity, For both therapist and client the analogy we draw here is with playing music – the practice may at first feel forced and stilted, but as both parties adjust to the subtleties and opportunities of an online environment, creative approaches to psychotherapeutic technique can be unlocked.

### **Conclusions**

The COVID-19 pandemic creates major challenges for provision of mental health services in general and specifically psychotherapy. These challenges are likely to

substantially change the way we conduct psychotherapy in the medium and long-term. However, these challenges also create opportunities for innovation –of which the current potential of telepsychotherapy is an excellent example. There are a number of groups that may benefit from telepsychotherapy including healthcare workers engaged in frontline response to the pandemic and their patients; individuals with new mental health distress as a function of COVID-19 diagnosis, or losing family and loved ones to the illness, or the psychological effects of prolonged physical distancing; and individuals with existing mental health conditions. In pivoting telepsychotherapy to meet increased need and reduce treatment burden the papers collected in this issue offer ample material to inform practical considerations, technique and address questions of effectiveness in telepsychotherapy. Going forward, evidence-based telepsychotherapy will require consideration of appropriate trial designs and implementation science to address questions of outcome and effectiveness, but also process and qualitative research to inform our understanding of technique and practice. In uncertain times we can and will be able to get beyond the curve. Finally, the value of this special issue, and indeed telepsychotherapy extends beyond the current pandemic. Telepsychotherapy offer promise for psychotherapists to prepare for future physical distancing situations, and may even offer opportunities to expand psychotherapy provision in challenging environments where access to mental health care due to crisis, conflict, natural disasters may be compromised.

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